COMMONWEALTH OF VIRGINIA

DEPARTMENT OF HUMAN RESOURCE MANAGEMENT

SARA REDDING WILSON
DIRECTOR

James Monroe Building
101 N. 14th Street
Richmond, Virginia 23219

To: State Retiree Health Benefits Program Participants Eligible for Medicare
(This includes Retirees, Survivors, Long Term Disability Participants and some eligible dependents who have separate, individual plans based on their Medicare eligibility)

From: Mary P. Habel, Director
State and Local Health Benefits Programs

Date: October 25, 2005

Re: •Medicare Part D And Its Effect On Your State Plan Coverage
•Medicare-Coordinating Plan Monthly Premium Rates Effective January 1, 2006
•Retiree Group Updates and General Information

The availability of Medicare Part D, the Medicare prescription drug benefit, has resulted in significant changes to your Commonwealth of Virginia prescription drug benefit and the options that are available to Medicare-eligible retiree group participants. It is important that you read these materials carefully in order to make the best choice available for your individual needs.

Your Prescription Drug Coverage

To ensure that our Medicare-eligible retiree group participants receive the value of the new Medicare Part D benefit, the Department of Human Resource Management has carefully reviewed the options available to plan sponsors, such as the Commonwealth of Virginia, that cover Medicare-primary participants (participants for whom Medicare pays first, such as retirees and others not covered due to current employment). Your new prescription drug coverage option applies the value of the Medicare Part D benefit in a plan that has some new and attractive co-payment opportunities. Also, this coverage will often provide benefits where the standard Medicare Part D benefit may present gaps (for example, the Medicare Part D deductible and "donut hole"). The Commonwealth of Virginia has contracted directly with an enhanced Medicare Part D Plan, administered by Medco, to offer this coverage.

If you elect to continue your prescription drug coverage under the State Retiree Health Benefits Program, you will automatically be enrolled in Medicare Part D, and you will receive the benefits of this enhanced Part D plan. However, if you prefer to obtain your prescription drug coverage directly through another Medicare Part D plan (not associated with the state program), or if you wish to discontinue your prescription drug coverage, you now have the option of selecting a state Medicare supplemental plan (Advantage 65-Medical Only) that does not include a prescription drug benefit. (If you decide to drop prescription drug coverage, be sure to consult your ***Medicare & You 2006*** publication so that you are aware of the consequences of being without creditable coverage.) Finally, applying the value of Medicare Part D to your state prescription drug coverage has also resulted in a significant reduction in premium for all plan options. Premiums for 2006 are listed on page 3.

Prescription Drug Benefit Provisions

If you choose to maintain prescription drug coverage under the state program (Advantage 65, Medicare Supplemental-Option II or Medicare Complementary-Option I), following are your prescription drug benefit provisions:

Formulary – Only drugs included on the plan's formulary will be covered. However, participants may apply for exceptions to formulary exclusions. Adverse exception decisions may be further appealed. You will receive in a separate mailing a *Summary of Benefits* that will include additional information about the exception and appeal processes. Starting November 1, you may check the formulary tier (e.g., generic, preferred brand, non-preferred brand, specialty drug, non-covered drug—as listed below) of any medication by contacting Medco at 1-800-572-4098 or going to its Web site: http://www.dhrm.virginia.gov/hbenefits/retirees/medicareretiree.html. This link takes you to the Department of Human Resource Management Web site—then just click on the *Medco—Medicare Part D Plan* quick link.

All prescription drug formularies offered by Medicare Part D Plans were approved by the Centers for Medicare and Medicaid Services (CMS). Most generic drugs (except those excluded by Medicare Part D) are covered under the new state plan formulary, and, as required by law, there are at least two drugs in every therapeutic category and class (unless there are not two drugs in that category/class). Participants have significant protections provided by law.

Deductible – a $250 deductible will apply to all covered drugs except generics. **There will be no deductible associated with covered generics**.

Co-payments

Drug Tier	Type of Drug/Method of Purchase	Your Co-payment Amount
Tier 1	Per 30-day supply of a covered **generic drug** at a participating retail pharmacy (up to a 90-day supply)	$4.00
Tier 1	Up to a 90-day supply of a covered **generic drug** purchased through the mail service program	$4.00
Tier 2	Per 30-day supply of a covered **preferred brand** at a participating retail pharmacy (up to a 90-day supply)	$17.00 (after deductible)
Tier 2	Up to a 90-day supply of a covered **preferred brand** purchased through the mail service program	$34.00 (after deductible)

Coinsurance

Drug Tier	Type of Drug/Method of Purchase	Your Coinsurance Amount
Tier 3	Per 30-day supply of a covered **non-preferred brand** at a participating retail pharmacy (up to a 90-day supply)	75% of the cost of the drug (after deductible)
Tier 3	Up to a 90-day supply of a covered **non-preferred brand** purchased through the mail service program	75% of the cost of the drug (after deductible)
Tier 4	Non-Covered Drugs	No Coverage – you pay 100% of the cost of the drug

Drug Tier	Type of Drug/Method of Purchase	Your Coinsurance Amount
Tier 5	Per 30-day supply of a covered **specialty drug** at a participating retail pharmacy	25% of the cost of the drug (after deductible)
Tier 5	Up to a 90-day supply of a covered **specialty drug** purchased through the mail service program	25% of the cost of the drug (after deductible)

Annual Out-of-Pocket Protection – After your annual out-of-pocket drug expense (not including the cost of excluded drugs) reaches $3,600, you will pay either a $2 (generic or preferred brand) or $5 (other drugs) co-payment or 5% coinsurance, whichever is greater. You will receive a monthly summary of your out-of-pocket expense directly from Medco.

Creditable Coverage – If elected, your prescription drug coverage under the state program has been determined, on average for all plan participants, to be at least as good as standard Medicare prescription drug coverage. It is, therefore, considered creditable coverage.

2006 Plans and Premium Levels

The following premium rates for Medicare-coordinating plan participants will be effective January 1, 2006:

Plan – Single Membership	Current (2005) Monthly Premium	Your Monthly Premium for 2006
Advantage 65	$293	**$220**
Advantage 65 + Dental/Vision	$320	**$249**
Medicare Complementary (Option I)	$259	**$183**
Medicare Supplemental (Option II)	$317	**$259**
Option II + Dental/Vision	$344	**$288**
NEW – Advantage 65—Medical Only*	Not Applicable	**$117**
NEW—Advantage 65—Medical Only + Dental/Vision*	Not Applicable	**$146**

*These new plans do not include prescription drug coverage.

All State Medicare-coordinating plan medical, dental and vision benefits are administered by Anthem Blue Cross and Blue Shield. For plans that include prescription drug coverage (all but the Advantage 65—Medical Only Plans), the drug benefit is administered by Medco.

!!! → Additional Information Needed ← !!!

If you wish to maintain prescription drug coverage under the state program, it is very important that you review your red, white and blue Medicare Health Insurance card. If your Medicare Claim Number is anything other than your Social Security Number with an A at the end, you must provide that identification number on the enclosed enrollment form in the space indicated and send it to your Benefits Administrator (indicated on form) so that it is received no later than November 30. (If possible, include a copy of your Medicare Health Insurance card.) **If we do not have your correct Medicare Claim Number, your state prescription drug coverage may not be available to you on January 1, 2006.**

Statewide Retiree Group Meetings Available to Participants

To assist you in making a decision about your Medicare supplemental coverage for 2006, the Department of Human Resource Management's Office of Health Benefits will conduct meetings around the state should you have additional questions or concerns about the new prescription drug option. A schedule of meetings is enclosed. If you plan to attend one of these meetings, be sure to bring the enclosed materials with you for reference**. While we have attempted to plan sufficient meetings in each area to accommodate a significant number of attendees, participation will be on a first-come/first-serve basis.**

Other Tools

Your enclosed *Open Forum* Newsletter contains additional information to assist you in making your coverage decision for 2006.

What Do You Need To Do?

If you wish to maintain your current benefit plan (Advantage 65, Option I, Option II), including the new prescription drug benefit, and you do not need to submit your Medicare Claim Number (see page 3), no action on your part is required. Your new monthly premium will automatically be deducted or billed in the usual manner.

If you wish to make a plan change for January 1, 2006, you must submit the enclosed Enrollment Form so that it is received by your Benefits Administrator no later than November 30, 2005. Requests for changes received after November 30 will be handled as quickly as possible but could result in a February 1 effective date. Forms received after December 31, 2005, will be effective the first of the month after they are received. If you wish to make an allowable change later than January 1, 2006, please request a standard enrollment form from your Benefits Administrator—the enclosed form is specifically designated for January 1, 2006, changes or updates. Forms must be signed by the Enrollee (Retiree, Survivor or LTD Participant); forms signed by a covered dependent will not be accepted. The following options are available:

- You may keep your current benefit plan (Advantage 65, Option I or Option II), including the prescription drug coverage described in this correspondence.
- You may elect the **Advantage 65—Medical Only** Plan. If you elect the medical-only plan, you will not have prescription drug coverage under the state program. This plan will supplement Medicare Parts A and B only (in addition to any other plan-specific coverage that is listed in your Member Handbook). It will be up to you to obtain prescription drug coverage elsewhere (for example, directly through a Medicare Prescription Drug Plan). Refer to your ***Medicare and You 2006*** publication for more information about other Medicare prescription drug plan choices. If you elect medical-only coverage, you will not have an opportunity to add prescription drug coverage under the state program in the future.
- You may terminate your state coverage completely, but you will not have the opportunity to return to the program at any time in the future. This will also result in the termination of coverage for any covered dependents.
- If you are in Advantage 65, or Medicare Supplemental—Option II (or Advantage 65—Medical Only after January 1), you may add Dental/Vision coverage one time and terminate it one time. Once you have terminated Dental/Vision coverage, you may not add it again.
- If you are in Medicare Complementary—Option I or Medicare Supplemental—Option II, you may move between those two plans on a prospective basis at any time. You may also change to the Advantage 65 Plan (including Advantage 65—Medical Only) at any time on a prospective basis. The effective date of either of these plan changes is generally the first of the month after your enrollment form is received; however, Advantage 65—Medical Only will not be available

until January 1, 2006. Once you have left either the Option I or Option II plans to enroll in any Advantage 65 plan, you may not re-enroll in Option I or Option II.

- Retirees, Survivors and LTD Participants may terminate dependent coverage at any time on a prospective basis. However, once dependent coverage has been terminated, dependents may only be added with the occurrence of a consistent qualifying mid-year event.
- All Medicare-eligible family members (e.g., retiree and spouse) may make separate plan elections.

For participants whose premiums are deducted from their VRS retirement annuity, the new January premium will be reflected in your February retirement payment. For those who pay through direct billing, your new January premium will be reflected in your December bill. For those who are paying through automatic bank draft, your first deduction in the new premium amount will take place in your January draft.

If you are currently being direct billed for your premium and, due to the reduction in your 2006 premium, your monthly retirement annuity will support your premium deduction, you may send a written request to the Virginia Retirement System (VRS) to begin deduction of your premium from your retirement annuity. However, you must be current in your direct bill payments in order to make this change.

Your Benefits Administrator – The enclosed Enrollment Form identifies the Benefits Administrator to whom your enrollment form should be sent should you choose to make a coverage change or need to update your Medicare Claim Number.

Other Important Retiree Program Information

New ID Cards/New ID Numbers – All participants will receive new ID cards in December for use starting January 1, 2006. You will receive an Anthem Blue Cross and Blue Shield Card for your medical benefits (including dental and vision if elected), and a Medco card for your prescription drug benefit (if elected). **They will reflect a new system-generated ID number for all participants**. (If you already have a system-generated ID number, it will not change on January 1, 2006.) Please be sure to present your new ID card when you receive any services after December 31, 2005.

New Member Handbooks – A new Member Handbook will be sent to you in January 2006.

No Benefit Level Changes for Your Medical or Dental/Vision Coverage – Other than the prescription drug coverage and premium changes addressed earlier in this correspondence, there will be no change in the Advantage 65, Medicare Complementary—Option I and Medicare Supplemental—Option II medical supplement benefit levels. However, while your plan benefit will not change, the Medicare Part B annual deductible will increase from $110 to $124 for 2006. If you have Dental/Vision coverage under your plan, there will be no change in those benefit provisions for 2006.

Medicare-Eligible Participants Under Age 65 – When an Enrollee (retiree, survivor, LTD participant) or a covered dependent becomes eligible for Medicare prior to age 65, an enrollment form must be submitted immediately to elect a Medicare-coordinating plan. While this letter is being directed to participants already enrolled in Medicare-coordinating plans, we provide this information to ensure that other covered family members in non-Medicare plans are also moved to a plan that coordinates with Medicare immediately upon eligibility. It is the responsibility of the Enrollee to ensure adherence to this provision. Failure to do so could result in significant coverage deficits.

This is an important provision of the State Retiree Health Benefits Program. All participants who are eligible for Medicare, regardless of age, must enroll in both Parts A and B in order to get the full benefit of any state Medicare supplemental coverage since Medicare becomes the primary payer

of claims. If you wish to obtain prescription drug coverage through the state program, enrollment for Medicare Part D will be automatic if you enroll in the Advantage 65 Plan immediately upon eligibility for Medicare. If you wish to stay in the state program but obtain your prescription drug benefit directly from another Medicare Part D plan, you must enroll in Medicare Part D when you enroll in Parts A and B. If it is determined that a retiree group participant is eligible for Medicare and has not enrolled in a Medicare-coordinating plan, he or she will be placed in the Advantage 65 Plan immediately. (The addition of Dental/Vision coverage to Advantage 65, if elected, will generally be effective the first of the month after an enrollment form is received.) Primary payments made in error by the state program will be retracted back to either the Medicare claim-filing limit, the date of Medicare eligibility or the date that retiree group coverage began. It will be the responsibility of the participant to arrange for submission of retracted claims to Medicare. If participants have declined Medicare coverage, it could result in a delay in enrollment and a critical gap in coverage until coverage goes into effect. The state plan will not pay any claims that should have been paid by Medicare had the participant been properly enrolled in Medicare coverage.

Prompt Payment of Premiums – Plan participants are responsible for timely payment of their monthly premiums (either through annuity deduction or by direct payment to the billing administrator). **Direct-bill retiree group participants who fail to pay their premium will have their claims put on hold (including prescription drugs, if applicable) until their premiums are paid.** Monthly premiums that remain unpaid for 31 days after the due date will result in termination of coverage. Once an Enrollee and his/her dependents have been terminated for non-payment of premiums, re-enrollment in the program is not allowed except in extreme circumstances and at the discretion of the Department of Human Resource Management. Direct-bill participants may enroll for automatic deduction of their monthly premium from their bank accounts. Contact Anthem for more information.

Participants are responsible for understanding their premium obligation and for notifying the program within 31 days of any qualifying mid-year event that affects eligibility and/or membership level. Premium overpayments due to failure of the Enrollee (Retiree, Survivor, LTD Participant) to advise the program of membership reductions may result in loss of the overpaid premium amount.

Resources for Retiree Group Participants – In addition to your Benefits Administrator and your plan's member handbook, there are many resources available at the Department of Human Resource Management's Web site to provide information to retiree group participants about their State Retiree Health Benefits Program coverage. Retiree Fact Sheets, which are available at the following link, contain subject-specific information directed to retiree group participants. Just go to http://www.dhrm.virginia.gov/hbenefits/retirees/medicareretiree.html.

Address Changes – Was this package forwarded to you from an old address? If so, be sure to contact your Benefits Administrator immediately to make an address correction. Failure to update your address can result in your missing important information about your health benefits program. The Department of Human Resource Management will not be responsible for information that participants miss because their address of record has not been corrected. The Department's only means of communicating important information to retiree group participants is through the mail. Please let us know when you move!

Enclosures: O*pen Forum* Newsletter
Enrollment Form
Meeting Schedule